STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89314-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 25th **day of July 2008**
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 21, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On May 28, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this matter can be resolved by analyzing the terms of the Petitioner's group coverage with Blue Care Network (BCN): the BCN 10 Certificate of Coverage (the certificate) and its applicable riders. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

On June 1, 2007, the Petitioner was conditionally enrolled in BCN's "enhanced" Healthy Living program which is described in the BCN Healthy Living Rider as "the BCN coverage

program designed to promote or maintain good health and/or prevent disease or the progression of disease for Members in the Program."

The enhanced program rewards members that maintain or adopt healthy behaviors by lowering their out-of-pocket costs. The enhanced program's benefits are available to members who score 80 points or more on an assessment of their current medical condition, lifestyle behaviors, and commitment to comply with the conditions of the program.

In order to remain in the enhanced program, the member must, within 90 days of enrollment,[1] complete a health risk assessment and enrollment form and commit to comply with certain behaviors recommended by their primary care physicians. Members who do not timely complete the enrollment process or are otherwise found to be ineligible are switched to a "standard" benefits program.

BCN terminated the Petitioner's enrollment in the Healthy Living program on October 30, 2007, and placed him in the standard program effective October 31, 2007, because he had not submitted any of the necessary forms.

The Petitioner appealed his termination from the enhanced program. He exhausted BCN's internal grievance process and received its final determination letter dated February 28, 2008.

III
ISSUE

Did BCN properly deny the Petitioner continued coverage in the Healthy Living Program?

[1] XXXXX employees, like the Petitioner, were given an additional 30 days to complete the process to remain in the enhanced program.

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that when he had coverage through M-Care and Aetna he did not have to do anything further after enrolling so he did not know that he had to take additional steps to maintain the enhanced coverage with BCN. He says he was never advised that he had requirements to fulfill in order to stay in the program. He believes BCN should perhaps have used e-mail instead of regular mail to inform him of the program's requirements.

He acknowledged that he might have received information from BCN about the enhanced program but says his wife may have put it in the recycle bin. He also says that he did not see his primary care physician until after the enrollment period had ended. The Petitioner says that if he had known there were other requirements to complete in order to stay in the enhanced plan he certainly would have fulfilled them.

The Petitioner asks to be retroactively enrolled in the Healthy Living program effective October 31, 2007.

Respondent's Argument

In its final adverse determination, BCN explained to the Petitioner why he had been switched from the enhanced to the standard program: "The required documentation to remain in the Enhanced benefit level was not submitted within the required time period. We did not receive your Health Risk Appraisal (HRA) form or your Health Qualification form (HQF) in the approved enrollment time period."

BCN says an initial enrollment kit was mailed to the Petitioner on May 18, 2007, and was followed by a reminder letter sent August 16, 2007. Since the Petitioner failed to meet the requirements for continued enrollment in the enhanced program, BCN says it acted according to the terms of the Healthy Living Rider and switched his coverage to the standard benefits program at the conclusion of the enrollment period.

Commissioner's Review

According to the plain terms of the Healthy Living Rider (and considering the extra 30-day extension for Ford employees), the Petitioner had until October 1, 2007, to complete the process for enrolling in the enhanced program. The fact that he did not submit the necessary information by that date is not in dispute. Accordingly, the Commissioner concludes that BCN was correct when it switched his coverage to the standard program on October 31, 2007.

The heart of the Petitioner's complaint is that he did not receive information about the need to complete the enrollment process and was therefore prevented from timely complying with its requirements. BCN, on the other hand, says it sent the Petitioner two separate mailings that explained his obligation to enroll.

This type of dispute is not one the Commissioner can resolve under the Patient's Right to Independent Review Act (PRIRA). The PRIRA process does not allow the Commissioner to make the kind of fact-finding that would be needed to support or refute the Petitioner's contention or order a remedy as a result. The Commissioner's role in this case is limited to determining if BCN correctly applied the terms and conditions of the certificate and its applicable riders. Based on the undisputed facts in this case, the Commissioner finds that it did.

V
ORDER

The Commissioner upholds BCN's February 28, 2008, final adverse determination as consistent with the Healthy Living rider.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner

of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.